Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

J JOHN STATSIKOWSKI MD
1307 8TH AVE # 202
FORT WORTH TX 76104

Respondent Name
VALLEY FORGE INSURANCE CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-09-5862-01

MFDR Date Received
FEBRUARY 2, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This charge was first 99205 I changed the code to 99204 on 08.18.2008, a copy of the HCFA is enclosed. The carrier states on the current EOB that the time for filing has expired. But I have mail and fax confirmation that they received the corrected claim before 90 days."

Amount in Dispute: $275.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is important to note that the provider includes in this billing a letter dated August 18, 2008 that was purportedly sent to CAN by fax at 214-775-4021 as reflected on the letter. I have requested a copy of the fax confirmation or transmittal page from the provider and have not received such documentation to date…Incidentally [sic], there were 3 faxes sent by the HCP to this right fax number (214-775-4021) from the provider's fax number 817-926-2315 on the morning of October 3, 2008. However, these are untimely as the last day of timely submittal is September 29, 2008. As reflected on EOR responsive to the billing received by CAN (Valley Forge Insurance Company) on October 7, 2008, the Carrier properly denied the bill as untimely."

Response Submitted by: Law Offices of Jeffrey M. Lust, 600 N. Pearl, Ste 1450, LB 156, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2008	99204, 73600-LT-WP, 73620-LT-WP, 99080-73	$275.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 24, 2008
   - 150 – Payer deems the information submitted does not support this level of service.
   - (850-203) CV: The level of E&M code submitted is not supported by Documentation $0.00
   - (900-030) CV: This charge was reviewed through the clinical validation program.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
   - (100) Any network reduction is in accordance with the network referenced above.
   - (113-001) Network import repricing – contracted provider

   Explanation of benefits dated October 27, 2008
   - 18 – Duplicate claim/service.
   - (999) $125.00 of the charges are duplicates of bill #88888961-H-827116-0. It has a total allowance of $71.29
   - 29 – The time limit for filing has expired $0.00

   Explanation of benefits dated August 4, 2008
   - 150 – Payer deems this information submitted does not support this level of service.
   - (850-203) CV: The level of E&M code submitted is not supported by documentation $0.00
   - (900-030) CV: This charge was reviewed through the clinical validation program.
   - 18 – Duplicate claim/service.
   - (999) $125.00 of the charges are duplicates of bill #88888961-H-827116-0. It has a total allowance of $71.29
   - 45 – Charges exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability.)
   - (100) Any network reduction is in accordance with the Network referenced above.
   - (113-001) Network import re-pricing-contracted provider

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The insurance carrier reduced or denied disputed services with reason code "45 – Charges exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (100) Any network reduction is in accordance with the Network referenced above and 113-001) Network import re-pricing-contracted provider." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
3. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within

95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/19/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.